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# Qualitative Analysis of Client Contacts that Occurred during the First Three Months of the Rethinking Care Project

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# Executive Summary

## The Rethinking Care Project

Rethinking Care (RTC) is a program funded by the Washington State Health and Recovery Services Administration (HRSA) within the state Department of Social and Health Services (DSHS). Its purpose is to improve the quality of health care and to reduce health care expenditures for Supplemental Security (SSI) recipients with co-occurring medical and mental health/substance abuse problems. The intervention consists of King County Care Partners (KCCP) nurse care managers providing care management, education, assistance, and coordination of medical services to eligible patients.

## Intent of the Client Contact Project

Each encounter with a client or with an individual associated with a client (such as a primary care provider) is recorded in the KCCP contact data base. The data base contains two types of information: discrete fields and open-ended comments. The Client Contact Project was funded to help KCCP learn more about the data base with the intent of identifying ways to improve it. We undertook three related efforts to do this: (1) Apply qualitative analytic methods to code the content of the open-ended comments, (2) Construct vignettes to illustrate typical nurse care manager and client activities, and (3) Summarize impressions/conclusions and recommendations. We focused our efforts on the contacts recorded in the KCCP contact data base during the 3½ month time period between February 3, and May 18, 2009.

## Conclusions and Recommendations

*   Scheduling and other activities that consume a large amount of nurse (RN) care manager time do not always require the core competencies of an RN. A division of labor with social workers and other staff could free RN time to engage in more focused evidence-based interventions for chronic medical problems.

*   The categories of contacts that emerged from qualitative analyses of the open-ended comments have the potential to inform a revision of the KCCP contact data base to make it more intuitive, clinically meaningful, and more efficient for the nurse care managers

*   Because clients appear to cluster in certain profiles (e.g., some with simultaneously active medical, mental health, and social issues while others have only one active issue and more functional self-management skills), we recommend future evaluation efforts include systematic study of such client profiles in relation to outcomes.

*   Although the analyses summarized in this report represent a good start on understanding the intervention being provided in the RTC project, they are limited by the information that has (and has not) been entered into the data base. For this reason, we recommend expanded inquiry in the future to supplement the available information in the KCCP data base to document

*   Although beyond the scope of the work carried out here, it will be important to define the structure of the intervention to assure uniformity across clinicians and linkage to an outcome monitoring system to facilitate client progress such as done in collaborative care models[1].

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[1] Gilbody, S., Bower, P., Fletcher, J., Richards, D., Sutton, A. J. (2006). Collaborative care for depression. A cumulative meta-analysis and review of longer-term outcomes. *Archives of Internal Medicine, 166*, 2314-2321. Katon, W., & Unutzer, J. (2006). Collaborative care models for depression. Time to move from evidence to practice. *Archives of Internal Medicine, 166*, 2304-2305.

# Table of Contents

# 1. Introduction

## 1.1 Background

Rethinking Care (RTC) is a program funded by the Washington State Health and Recovery Services Administration (HRSA) within the state Department of Social and Health Services (DSHS). The Rethinking Care Program is being carried out in collaboration with King County Care Partners (KCCP) and the Center for Healthcare Strategies (CHCS). Its purpose is to improve the quality of health care and to reduce health care expenditures for Supplemental Security Insurance (SSI) recipients with co-occurring medical and mental health/substance abuse problems.

The RTC Program began enrolling clients in February 2009. Over the course of the two-year project, it is expected that approximately 1,560 eligible King County SSI recipients will be randomly assigned to either the RTC intervention or to a treatment-as-usual abeyance group. To be eligible for the RTC Program, SSI recipients must have at least one chronic physical condition and evidence of mental health problems, substance abuse, or both. In addition, SSI recipients must have been assessed as having a risk of future health care costs 50% or higher than the average Medicaid SSI client (i.e., risk score of 1.5 or higher) to be eligible.

King County Care Partners are responsible for providing the intervention to clients enrolled in the RTC project. The intervention consists of providing care management, education, assistance, and coordination of medical services to eligible patients. King County Care Partners describe themselves as offering an integrated approach to care management through:

- Assessment of risk factors, health status, self-management skills
- Assistance with adherence to provider's treatment plan and prescribed medications
- Development of a care plan specific to identified risks
- Facilitation of the development of a medical treatment plan with the patient's provider if one does not exist
- Referral to services that address unmet needs identified in assessment

## 1.2 King County Care Partners (KCCP) Contact Data Base

Each encounter with a client or with an individual associated with a client such as a primary care provider (i.e., "collateral") is recorded in the KCCP Contact Data Base. The recorded information is of two types: discrete fields and open-ended comments. The *discrete fields/codes* include: mode of contact (i.e., phone, online, home visit, letter, in person, clinic visit, fax), type of contact (i.e., scheduling, monitoring, review, referral, nurse assessment, education, PRA completed, termination, case staffing, document upload), and result of contact (i.e., "unsuccessful", message left, "successful", assigned, opt out, ineligible, enrolled). *Open-ended comments* are entered as text following most encounters.

## 1.3. Intent of Client Contact Project

Rethinking Care is a new program and the KCCP Contact Data Base is still under development. As such, it was viewed as a good point in time to review the type of data being collected and how it could be improved. For this reason, the Client Contact Project was funded to help KCCP learn more about the KCCP Contact Data Base with the intent of identifying ways to improve it. In particular, KCCP had an interest in finding ways to make the discrete fields more intuitive and clinically meaningful. They were also interested in making data entry more efficient and reliable by increasing the number of discrete fields (or, 'check boxes') that could be entered to reduce, at least in part, the need to enter extensive (and labor-intensive) open-ended comments while still retaining all the important information contained in the comments.

We undertook three related efforts to carry out the project. The first was directed at learning more about the content of the open-ended comments; we used content analysis, a qualitative analytic method, to identify primary categories in the data base. Second, also using qualitative analytic methods, we constructed vignettes to illustrate a typical day in the life of a Nurse Care Manager (RNCM). We also constructed vignettes for four clients. Finally, we provide a set of impressions or conclusions we drew from these efforts along with a set of recommendations.
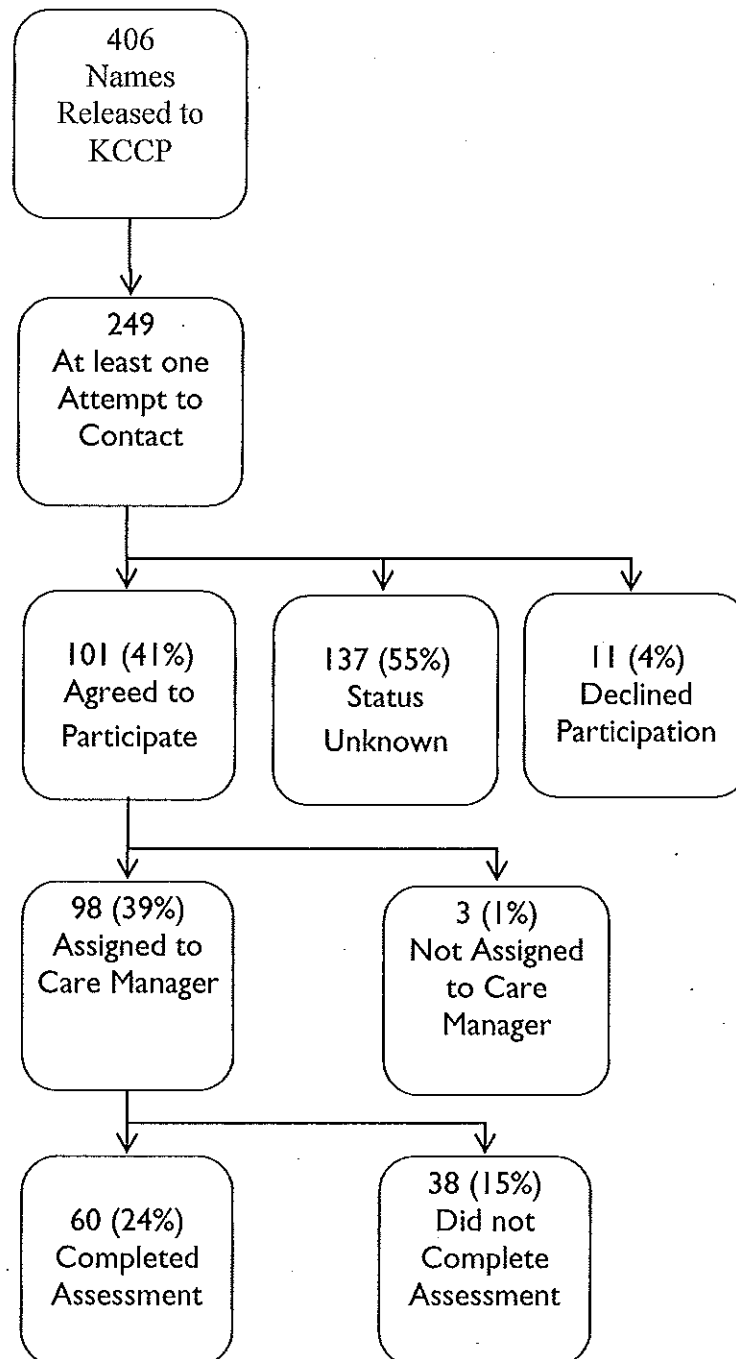
## 1.4. Overview of Methods

The Client Contact Project was designed to describe the frequency, intensity, duration, and types of contact between RTC clients and Care Managers. As described earlier, clients began enrolling into the RTC project in February, 2009[2]. We focused our efforts on the contacts recorded in the KCCP contact data base between Care Managers and clients that took place in the 3½ month time period between February 3, 2009 and May 18, 2009. Three Nurse Care Managers (RNCM) and two social workers (ADSCM) were involved in providing the RTC intervention during this time period.

Figure 1 provides an overview of client flow. During the first 3½ months of the project, 406 client names were released to KCCP to be contacted. During this time period, either a RNCM or an Information and Assistance staff member (I&A) made at least one attempt to contact 249 of the 406.

Of the 249 clients, 101 clients (41%) agreed to participate in the RTC Project. The qualitative analyses were based on these 101 clients. Most of the 101 individuals (98) were assigned to a care manager, with 60 of them completing a preliminary nurse assessment within the time frame we examined.

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[2] The KCCP contact data base contained data for both the RTC Project and an earlier project called, KCCP. We distinguished RTC clients from KCCP clients by linking them with Medicaid PIC codes (i.e., Insurance ID's) that were contained in a separate file (i.e., 'Premium file'). We also double-checked that clients had a first contact no earlier than February 3, 2009.

Figure 1. Overview of client flow



Figure 1. Overview of client flow

| | | |
|---|---|---|
| 406 Names Released to KCCP | | |
| ↓ | | |
| 249 At least one Attempt to Contact | | |
| 101 (41%) Agreed to Participate | 137 (55%) Status Unknown | 11 (4%) Declined Participation |
| 98 (39%) Assigned to Care Manager | 3 (1%) Not Assigned to Care Manager | |
| 60 (24%) Completed Assessment | 38 (15%) Did not Complete Assessment | |

## 2. Qualitative Analyses

The qualitative analyses were focused on learning more about the content of the open-ended comments. There are four components to this work. First, we used content analysis, a qualitative analytic method, to identify primary categories in the data base under which all information could be organized. Second, we provide a brief description of what care managers do based on the information contained in the content analysis. Third, also using qualitative analytic methods, we constructed vignettes to illustrate a typical day in the life of a Nurse Care Manager (RNCM). We also constructed vignettes for four clients. Finally, we provide a set of impressions or conclusions we drew from these efforts along with a set of recommendations.

### 2.1 Primary Categories Coded from the Open-Ended Comments
A content analysis was used to identify primary categories in the data base under which all information in the open-ended comments could be organized. We used Atlas, ti, a qualitative data analytic software tool, to code open-ended comments in the KCCP contact data base. To create codes, one member of the research team read the full text of the contact log several times. Through an iterative process of assigning codes by reading the full text of the contact log multiple times, and reporting codes to and receiving feedback from the three other research team members once a week over a period of approximately a month, four major code categories, multiple subcategories, and numerous codes were constructed.

The four major code categories are 'Staff' (staff member), 'Mode of Contact' (e.g. phone), 'Intervention' (type of intervention), and 'Qualifiers' (additional qualifying information). 'Staff' is divided in to two categories: Role, and Staff (by name). 'Mode of Contact' contains: In Person (e.g. meetings), Phone, Email, Fax, Letter, Other, and Recruiting (all contacts related solely to recruiting). 'Intervention' is divided into: Client Status (e.g. Assigned), Interventions with the Client, and Interventions for the Client (on behalf of the client). 'Qualifiers' include reasons for ineligibility and missed appointments, further specificity of interventions, client qualifiers, collateral contact qualifiers, medical qualifiers, psychosocial qualifiers, and organizations and programs with which clients are involved. *A complete list of these codes is included as Appendix A.*

Because these codes were derived from open-ended comments made by the RNCMs , we believe they have high face validity and, as such, are also likely to be viewed as intuitive and clinically meaningful by RTC intervention staff. Thus, they offer a useful resource when considering ways to revise the discrete fields in the KCCP contact data base.

In particular, it would be useful to consider using the codes under 'Mode of Contact' as a framework for data base revision with some clarification (say, in the form of focus groups) from RNCM and other RTC intervention staff. Based on the data base notes, the 'Mode of Contact' codes very accurately reflect the range and specificity of contact activities. The codes for 'Intervention' and 'Qualifiers' can also be used as a start to clarify more specific categories but would need more input and collaboration from RTC intervention staff than 'Mode of Contact' before they could be used in a revision of the data base.

## 2.2 Qualitative Summary

A brief description of what case managers do:

- First thing case managers do is make phone call to schedule the assessment
- Next, they conduct the assessment and, in collaboration with the client, develop the clients' goals
- They then work with the client to determine how to address the client's goals and to more effectively self-manage their health
    - By attending appointments with medical providers
    - Through phone calls/meetings
    - By arranging for services for clients
    - By problem-solving with clients about specific problems/issues
    - By coordinating care with other providers
    - By scheduling appointments for clients

## 2.3 Nurse Case Manager (RNCM) Vignettes: A Day in the Life of A Nurse Case Manager

In order to convey the richness of the available data that illustrate RNCM's activities, we present vignettes for three case managers on two randomly selected days (4/15/09 and 5/15/09). It should be noted that RNCM's were not only responsible for providing interventions to RTC clients but were also responsible for providing interventions to clients from an earlier project called, KCCP.

### 2.3.1 RNCM #1 (4/15/09)

> *2.3.1.1 Summary.*
> 7 Clients (2 RTC, 5 KCCP)
> - 3 In-Person Appointments
>     - 1 Initial Nurse Assessment completed (RTC)
>     - 2 Primary Care Appointments attended (1 RTC, 1 KCCP)
> - 5 Phone Calls
>     - 1 Phone Call to dental provider to schedule appointment (KCCP)
>     - 1 Phone Call to medical provider to coordinate care (KCCP)
>     - 2 Phone Calls to clients re: appointment scheduling (2 KCCP)
>     - 1 Phone Call to family member for care coordination (KCCP)
> - 1 Letter Sent to Client Re: Self-Care Goals (KCCP)

*2.3.1.2 Description.*

On 4/15/09, RNCM #1 met with two RTC clients in person. She attended a primary care medical appointment in Kent for a Russian speaking client and went to another client's home for the initial nurse assessment.

In addition, RNCM #1 worked with or on behalf of five additional KCCP clients enrolled before the RTC Project. She attended a primary care medical appointment with a client in Northgate.

She sent a follow-up letter confirming mutual self-care goals to another.

She returned a call to a client's mother about an upcoming appointment with a PCP and clinic social worker to which the mother planned on transporting the client. The RNCM subsequently left a voicemail for the social worker at the primary care clinic stating that she would not be able to attend the appointment, but asking that back pain, depression, and dermatology be addressed.

For another client she attempted to schedule a dental appointment, but was unsuccessful due to being put on hold for over an hour. The RNCM called the client and informed her of her attempt to schedule, stated she would try again, and also informed client of the clinic's walk-in hours.

She returned a call to the final client of the day stating she would not be able to attend her scheduled primary care appointment due to a meeting scheduled at that time.

### 2.3.2 RNCM #2 (4/15/09)

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2.3.2.1 Summary. 8 Clients (3 RTC, 5 KCCP)
- 2 In-Person Appointments
  - 1 Home Visit (RTC)
  - 1 Initial Nurse Assessment (RTC)
- 10 Phone Calls
  - 1 Phone Call from client requesting assistance (RTC)
  - 5 Phone Calls to clients re: appointment scheduling (1 RTC, 4 KCCP)
  - 1 Phone Call from medical provider to coordinate care (RTC)
  - 2 Phone Calls to medical providers to coordinate care (1 RTC, 1 KCCP)
  - 1 Phone Call to social service provider to coordinate care (KCCP)

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2.3.2.2 Description.
On 4/15/09, RNCM #2 took a phone call from an RTC client requesting laundry detergent. She explained that someone from Aging and Disability Services (ADS) would be taking him toiletries the next day and that the ADS case manager would also meet with him the next day to help with his housing issues. The RNCM then called the client's primary care provider to request and increase in his pain medications. She was informed that the client would have to make an appointment to see the Primary Care Provider (PCP). When she called the client to tell him this, he expressed frustration, stating that he had already tried to make an appointment but the earliest was in two months and he did not feel he could wait that long.

RNCM #2 made a home visit to another RTC client to discuss the client's wish to disenroll from her mental health provider, Seattle Mental Health, and the services they offer, including supportive housing, to move in with her new husband who is mentally disabled as well. The RNCM utilized cognitive behavioral techniques for the discussion.

For the third and final RTC client of the day, RNCM #2 took a return phone call from the nurse at the patient's primary care clinic in response to the RNCM's request for diabetes education for her non-English speaking client. The nurse informed the RNCM that the client should use the diabetic food pyramid and be referred to Highline Hospital for education with a translator. The RNCM then went to the client's home for the initial nurse assessment and the client declined to continue with the RTC program.

In addition, RNCM #2 worked with or on behalf of five additional KCCP clients enrolled before the RTC Project. She called four clients to schedule or reschedule home visits. One client had already missed two appointments, which she stated was due to her symptoms of borderline personality disorder, but she rescheduled a third. The second client requested they complete the visit by phone because her brother-in-law does not like having people in the house. The RNCM agreed to the phone visit for just that time and suggested they meet out of the client's home the next time. The third client, who had cancelled the previous appointment didn't answer the phone, and the RNCM left the fourth a message with possible dates.

The RNCM also contacted collateral health care and social service providers for a client to schedule a meeting for care coordination.

### 2.3.3 RNCM #3 (4/15/09)

> *2.3.3.1 Summary.*
> 5 Clients (1 RTC, 4 KCCP)
> * 7 Phone Calls
>     * o   1 Phone Call from client requesting assistance (RTC)
>     * o   5 Phone Calls to clients re: appointment scheduling, follow-up (5 KCCP)
>     * o   1 Phone Call to medical provider to schedule appointment (KCCP)

   *2.3.3.2 Description.*
On 4/15/09, RNCM #3 received a voicemail from an RTC client stating that he had lost his paperwork for dental services and housing. In addition, RNCM #2 worked with or on behalf of three additional KCCP clients enrolled before the RTC Project.

The RNCM contacted a client three times by phone to follow-up on her status and well-being, and to confirm scheduling for primary care and various medical specialty appointments. She also called the client's primary care provider to schedule an appointment.

She returned a client call about a contact information update, and the success of physical therapy in reducing the client's pain.

The RNCM also returned a client call regarding medication concerns and DSHS pharmacy and care provider restrictions.

## 2.3.4 RNCM #1 (5/15/09)

> ### 2.3.4.1 Summary.
> 18 Clients (9 RTC, 9 KCCP)
> - 2 In-Person Appointments
>   - 1 Attempted Initial Nurse Assessment – client no show (RTC)
>   - 1 Medical Appointment attended (RTC)
> - 17 Phone Calls
>   - 1 Phone Call from client requesting assistance (KCCP)
>   - 6 Phone Calls to clients re: self-care goals and follow-up (4 RTC, 2 KCCP)
>   - 4 Phone Calls to clients re: appointment scheduling (3 RTC, 1 KCCP)
>   - 1 Phone Call to social service provider to coordinate care (RTC)
>   - 1 Phone Call to mental health provider to coordinate care (RTC)
>   - 4 Phone Calls to medical providers to coordinate care (2 RTC, 2 KCCP)
> - 2 Letters
>   - 1 Letter to client re: appointment scheduling (RTC)
>   - 1 Letter to social service provider re: transportation (RCT)
> - 2 Reviews of Medical Records (1 RTC, 1 KCCP)

### 2.3.4.2 Description.

On 5/15/09 RNCM #1 went to an RTC client's neurology rehabilitation appointment. The night before the patient had been to the emergency room for a hand injury and also had a scheduled follow-up that day with a hand specialist. The RNCM called the specialty hand clinic to inform them that she would not be able to attend with the client. They informed her that the client had arrived at the clinic but forgotten his paperwork from the ER, so would be seen later after going to get it. Later in the day the RNCM called the nurse at the hand clinic who reported that the patient had been treated, instructed in wound care, and given supplies. The RNCM also made two calls on behalf of the client. She left a message at DSHS indicating the client's choices of PCP, pharmacy, and non-urgent use hospital. She also left a message for the client's mental health provider informing that she had obtained a letter of medical clearance for the client to attend inpatient chemical dependency treatment which she would bring to the client's next mental health appointment. She also mailed an ACCESS transportation application for the client.

RNCM #1 also attempted to do an initial nurse assessment at a client's home on 5/15 but the client was not there. She called the client multiple times without success. The RNCM found another phone number for the client in her hospital contact data. She reached the client who apologized and stated that she had been at the eye doctor. They rescheduled the visit and the RNCM mailed a letter of confirmation to the client.

The RNCM made four calls to four different clients to address their self-care goals, a psychiatry appointment one had attended, and diabetes education classes for two of them. She made one call to schedule an initial nurse assessment and left a message for the client. She also reviewed the medical records of a client who had been seen in epilepsy, chronic fatigue, and orthopedic clinics.

In addition, RNCM #1 worked with or on behalf of nine additional KCCP clients enrolled before the RTC Project. She had phone conversations with a chemical dependency case manager and a medical clinic to coordinate care for a client. She called and spoke to three clients about an appointment she had scheduled, progress after hip replacement surgery, and physical therapy, respectively. She made three calls to clients for whom she left messages, and reviewed a medical record. She also took a call from a client asking for help with an eviction notice he had received that day.

### 2.3.5 RNCM Vignette #2 (5/15/09)

> *2.3.5.1 Summary.*
> 13 Clients (9 RTC, 4 KCCP)
> - 2 Attempted In-Person Appointments
>   - o  1 Attempted Mental Health Appointment- client no-show (RTC)
>   - o  1 Attempted Home Visit – client no show (KCCP)
> - 11 Phone Calls
>   - o  1 Phone Call from client requesting assistance (RTC)
>   - o  1 Phone Call from client cancelling scheduled appointment (RTC)
>   - o  9 Phone Calls to Clients re: appointment scheduling (5 RTC, 4 KCCP)
> - 1 Fax from primary care provider re: care coordination (RTC)

*2.3.5.2 Description.*
On 5/15/09 RNCM #2 went to an RTC client's appointment with his mental health case manager but the client did not show up. She received a call from a client stating she was not feeling well and needed to cancel the home visit scheduled for that day. She called three clients and successfully scheduled appointments with all of them. She left two additional clients messages about scheduling appointments with them. She received a fax from a primary care clinic nurse with the results of labs for the previous six months. She also received a call from a client requesting help for a case regarding insurance eligibility for which he was going to court.

In addition, RNCM #2 worked with or on behalf of four additional KCCP clients enrolled before the RTC Project. She went to a client's for a scheduled home visit, but the client was not there. She rescheduled the appointment with her and scheduled new appointments with three clients.

### 2.3.6 RNCM Vignette #3 (5/15/09)

> *2.3.6.1 Summary.*
> 5 Clients (5 KCCP)
> - 5 Phone Calls
>   - o  2 Phone Calls from Clients re: appointment scheduling, support
>   - o  1 Phone Call to Client re: appointment scheduling
>   - o  1 Phone Call to social service provider to coordinate care
>   - o  1 Phone Call to primary care provider to coordinate care

*2.3.6.2 Description.*

On 5/15/09 RNCM #3 worked with or on behalf of five KCCP clients enrolled before the RTC Project. She received two calls from clients, one wanting to schedule a visit and the other who had been calling daily for support. She called another client to schedule an appointment and left a message. The RNCM coordinated care with a client's ADS case manager. She also called a client's primary care clinic for her, as the client was feeling anxious about communicating her concerns to the clinic staff herself.

## 2.4 CLIENT VIGNETTES—4 CLIENTS

In order to convey the richness of contact data that appear in the open-ended comments of the KCCP Contact Data Base, we provide descriptive vignettes for four clients. We selected these four clients from the pool of available clients using the following method: Rethinking Care clients were put in descending order of highest frequency of contact, represented by the "Mode of Contact" column in the Atlas.ti Codes (Appendix A). From the twenty clients who had the most contact from mid-February 2009 until early June 2009, four were randomly selected for the client vignettes. Since the project is accruing clients by rolling admission, high frequency of contact indicates clients have enrolled earlier and have been relatively active in the program, or demand more attention than the average client, or both.

### 2.4.1 Client #1 (3/2/09 – 5/15/09)

> *2.4.1.1 Summary.*
> Client 1 has significant cognitive deficits and substance dependencies (narcotics and alcohol). Because of his cognitive deficits the client needed a tremendous amount of feedback and reminding regarding his goals, care, and appointments. He called the RNCM (nurse care manager) almost every day at times asking for reassurance and confirmation of appointments. On enrollment in RTC he did not have a primary care provider. Between early March and mid May 2009, the RTC team helped the client establish primary care. During this time the RNCM also attended a mental health appointment with the client and began the process of aiding the client in going to inpatient chemical dependency treatment by obtaining a letter of medical clearance for him. The ADSCM (ADS case manager) worked on helping the client get housing and ACCESS Transportation applications authorized by a medical provider without success as of mid May. The RNCM also got the client established with neurology rehabilitation specialty care, accompanying him to his first appointment, and coordinated care with a specialty clinic after the patient presented at an emergency room with an acute hand injury.

> *2.4.1.2 Enrollment.*
Client 1 (7001496) was enrolled by I&A (Senior Information and Assistance) on their third attempted contact by phone. The client abuses alcohol and narcotics and has some cognitive deficits. On enrollment he reported not having a primary care provider. He was thought to be living in SeaMar Community Care AFH (adult family home), but when the RNCM (registered nurse case manager) made her initial client contact attempt, the AFH staff told her there was no one by client's name living there. She reached the client on his mobile phone and he reported he was staying with his brother, but was not sure how long that arrangement would last. During call the RNCM scheduled the Nurse Assessment at his brother's home.

### 2.4.1.3 Nurse Assessment.

Shortly after scheduling the Nurse Assessment the client left a message for the RNCM reporting with "slurred" speech that he had been "walking", but was experiencing "pain in the leg they put the rod in". From the time the Nurse Assessment was scheduled until it took place, the client called the RNCM nine times, leaving messages asking for call backs due to confusion about the date and time of his assessment. The RNCM made a total of four call backs to the client confirming the date, time, and place. After the third call back she also sent the client a letter with the details of the upcoming assessment date and time. The ADSCM (Aging and Disability Services case manager) also called the client to confirm the date and time of his assessment appointment. During the call the client reported he did not know the current day and date and the ADSCM had to orient him.

The ADSCM prepared the file for the Nurse Assessment. The Nurse Assessment was successfully completed on the scheduled date and time. The ADSCM accompanied the RNCM to the client's brother's home for the assessment. The client's brother reviewed all the documents. After the assessment the RNCM mailed the client a list of referrals for low cost dental care in King County and a Narcotics Anonymous schedule.

### 2.4.1.4 Transportation and Housing.

The RNCM called Hopelink Transportation on behalf of client to confirm his current ride benefits and mailed the client a Metro ACCESS application on his request.

The ADSCM called Metro ACCESS on the client's behalf, informing them that the card they had sent to the client had the wrong name on it. In addition she downloaded a King County Housing application for the client and mailed it to him, along with a calendar to help him remember his appointments.

The ADSCM called the client to follow up on an unspecified medical appointment, during which time the client informed her that the clinic staff at the appointment couldn't fill out his Metro ACCESS application because they are not his primary provider.

The ADSCM called client, who sounded "very sleepy" to follow-up about the Metro ACCESS and housing applications. She reminded him that he had a neurology rehabilitation appointment at Harborview (HMC) that would be attended by RNCM, and that he should bring the Metro and housing documents with him to the appointment.

### 2.4.1.5 Establishing Primary Care.

The RNCM called Harborview Adult Medicine to make an appointment for the client to establish primary care, but was informed that it could be a six to nine month wait.

The RNCM called SeaMar Clinic and scheduled an appointment for the client to establish primary care.

The RNCM called PRC/DSHS to inform them of client's choices for PCP (primary care provider), pharmacy, and non-urgent hospital.

### 2.4.1.6 Mental Health and Chemical Dependency Treatment.

The client called the RNCM and left a message inquiring whether she was going to accompany him to a medical appointment at "Valley". The RNCM returned the client's call informing him that she would not be able to attend due to a prior commitment. During this call the client reported he was recording his appointments on the calendar the ADSCM mailed him, yet when asked what time his appointment with the CDP (chemical dependency professional) at Navos Mental Health was, the client wasn't sure. The RNCM called Navos to confirm the appointment time for the client. On the day of the appointment at Navos, the RNCM called the client to inform him that she would not be able to attend due to a previous engagement.

The client left a voicemail for the RNCM informing her of an appointment with Navos CDP and asking him whether she would be attending with him. RNCM returned the call stating she would attend the appointment. At the appointment the client confirmed he would like to get in to chemical dependency treatment at Thunderbird in the next several months because he would like to quit drinking.

The RNCM called CDP at Navos Mental Health to inform that she had a "letter of medical clearance" for the client to attend Thunderbird Treatment Center, and that she would attend the next scheduled Navos CDP appointment with client.

### 2.4.1.7 Neurology Rehabilitation.
The RNCM called Hopelink Transportation and scheduled a taxi for client's appointment at the HMC Neurology Rehabilitation Clinic. When she called the client to remind him of his appointment and inform him about his taxi there, the client stated he did not know the location of the clinic. The RNCM called the clinic to get the location, then let the client know the address and instructed him to meet her in front of the building. Later she received a message from the client marked "urgent" stating he couldn't remember the appointment date and time and didn't know whether he had to call Hopelink Transportation to arrange a taxi to it. The RNCM returned call to the client and reconfirmed the details.

The client and RNCM attended the appointment at the HMC Neurology Rehabilitation Clinic, after which the RNCM accompanied the client to the HMC Pharmacy to fill a prescription he had been given the night before at the Swedish ER where he had gone for a hand injury. The HMC Pharmacy informed them that they only fill HMC prescriptions, so the client called his brother who said he would try to get it filled later.

### 2.4.1.8. Acute Wound Care.
The RNCM called the client to inform him she wouldn't be able to attend his appointment at the Seattle Hand Clinic, where he was referred by the Swedish ER. She also called the clinic to introduce herself and inform them she wouldn't be able to attend the appointment. They informed her that the client had forgotten his referral papers from Swedish so they wouldn't be able to see him that day.

The RNCM called the Seattle Hand Clinic to follow-up on the client's rescheduled visit. The clinic MA (medical assistant) informed the RNCM that the client had successfully seen the physician at the clinic and had been instructed in wound care and given dressing supplies.
### 2.4.1.9 Older Adult Services.

The ADSCM called ElderPlace on behalf of client, but was informed that client didn't meet the age criteria for the program.

### 2.4.1.10 Client Goals Follow-up.
The RNCM called the client to follow up on "self-care" goals. The client seemed "disjointed", reporting he had lost his wallet "again", including all his ID. Said he was having difficulty remembering things.

## 2.4.2 Client #2 (2/12/09 – 5/15/09)

### 2.4.2.1 Summary.
On enrollment Client 2 was engaged in primary care, oncology and mental health treatment. She was spending most of her time in bed due to lack of energy. The RNCM mainly supported and facilitated the client in her goal of Coumadin management and regular INR checks. At times it was difficult to track the patient because she had two inpatient hospitalizations for pulmonary embolisms between mid February and mid May 2009. The RNCM also followed the client's depression treatment. The client had some difficulty getting Hopelink Transportation approval from her PCP, so the RNCM communicated with her primary care clinic to facilitate the completion of the paperwork.

### 2.4.2.2 Enrollment.
Client 2 (7003821) was enrolled by I&A on their third attempted contact by phone. The client's PCP is at the Country Doctor and she also receives care from an oncologist at Swedish Cancer Institute. She receives mental health treatment for depression. She suffers from decreased energy and spends most of her time in bed.

### 2.4.2.3 Nurse Assessment.
The RNCM called the client and scheduled the Nurse Assessment which was completed on the scheduled date and time. After the assessment the RNCM sent the client a letter with medical education about Coumadin.

### 2.4.2.4 Pulmonary Embolism Hospitalization.
The RNCM called the client to follow-up on the client's oncologist appointment and her self-care goal of INR checks. She left a message for the client to return the call. The RNCM called the client a second time regarding the oncologist appointment and INR checks. The client reported she had been hospitalized at Swedish Medical Center for a blood clot to her lungs and was just recently discharged. The RNCM called the client again to follow-up on her self-care goals but spoke instead to her sister who reported that the client was once again back in the hospital. The RNCM called the client an additional time and left a voice message asking for a return call.

The ADSCM also called client to follow-up on her most recent hospitalization. The client reported she is doing better, working on her goals, and will be able to attend her upcoming PCP appointment at the Country Doctor.

### 2.4.2.5 Primary Care and Transportation Eligibility; Outpatient Oncology and INR.

The RNCM attempted to attend the client's PCP appointment, but the receptionist at the Country Doctor informed her that it had been rescheduled for a later date. When the RNCM asked if she could speak to the client's PCP or PCP's nurse, the receptionist said it would not be possible that day.

The RNCM called the client to confirm the date and time of the rescheduled PCP visit and follow-up on client's well being and self-care goals. There was no answer so the RNCM left a voice message requesting a call back. The RNCM called the client a second time, but this time couldn't leave a message, as there was no answer or voicemail. The RNCM attempted to call the client again with success. The client reported she had an upcoming oncology appointment and needed to reschedule her appointment at the Country Doctor again because Hopelink Transportation requested documentation from her PCP that she needed to travel to the Country Doctor *specifically*, rather than a clinic closer to her home.

The RNCM called the client to follow-up on her PCP visit and self-care goals. The client did not answer so the RNCM left a message requesting a return call. The client returned the call to the RNCM, leaving a voice message requesting she call her PCP's nurse at Country Doctor to facilitate paperwork for Hopelink Transportation eligibility.

The RNCM left a message for the client's PCP's nurse at the Country Doctor, explaining what the client needs from them for Hopelink Transportation approval.

The RNCM left a voice message for the client explaining that she would not be able to attend her upcoming oncology appointment due to a prior commitment, and informing her that she left a message regarding Hopelink Transportation documentation for her PCP's nurse at Country Doctor.

The PCP's nurse at Country Doctor returned the RNCM's call, stating that PCP feels the patient needs to come in for an exam to verify eligibility for Hopelink Transportation despite the RNCM's explanation that the patient has had two recent hospitalizations for pulmonary embolisms. The RNCM scheduled an appointment for the client at the Country Doctor for an exam.

The RNCM called Hopelink Transportation who informed that they would fax the client's PCP a "client necessity for transportation" form. The Hopelink staff informed the RNCM that all cancer patients automatically qualify for Hopelink Transportation and the client would not be turned down for a ride.

The RNCM called the client and left a voice message indicating that Hopelink Transportation was faxing the necessary paperwork to her PCP's office, and informed her of the appointment she scheduled with her PCP for an exam. The client returned the call confirming that the scheduled time and date for the exam with her PCP is fine. The RNCM shared with the client that she automatically qualifies for Hopelink transportation based on her cancer diagnosis.

The RNCM called the client to follow-up on her oncology appointment. The client reported that the oncologist increased her Coumadin dose and wants her to continue regular visits to the lab for INR checks.

### 2.4.2.6 Psychiatry.
The RNCM called the client to follow-up on her psychiatry appointment. The client informed that it was rescheduled for a later date. She reported that she restarted taking Zoloft on her own that day and confirmed she received the depression inventory the RNCM had sent.

## 2.4.3 Client #3 (2/17/09 – 5/8/09)

> ### 3.4.3.1 Summary.
> On enrollment Client 3 had a history of frequent ER visits and hospitalizations for diabetes complications (DKA, HHNK) generally due to poor self-management. The patient was hospitalized shortly after enrollment in RTC due to drinking lots of sweet tea drinks over the weekend. He signed out of this hospitalization AMA (against medical advice). The RNCM apprised the client of all his primary care appointments, followed up with the client after them, and interfaced with the PCP about the client's labs, medications, and diabetic teaching. From these efforts the client began to monitor his blood glucose with increasing regularity. At one point the client's glucometer was stolen and the RNCM facilitated a replacement with his pharmacy. The RNCM also attended a podiatry appointment with the client.

### 2.4.3.2 Enrollment.
Client 3 (4542) was enrolled by I&A on their second attempted contact by phone. The client is seen at HMC Adult Medicine. Review of his medical records by the RNCM indicated he has diabetes with numerous episodes of DKA (diabetic ketoacidosis) and HHNK (hyperglycemic hyperosmolar nonketotic coma) for which he has had frequent ER visits and hospital admissions.

### 2.4.3.3 Nurse Assessment.
The RNCM called the client and left a message requesting a call back to schedule the Nurse Assessment. When the RNCM called a second time, she successfully reached the client and scheduled the assessment. At the client's request the RNCM called the client to remind him of the time and date of their appointment. The Nurse Assessment was successfully completed on the scheduled date and time. After the assessment the RNCM sent the client a letter containing medical education on diabetes and depression, and contact information for the King County Crisis Clinic and King County Metro.

### 2.4.3.4 Diabetic Crisis Hospitalization.
The client called the RNCM to report that he was hospitalized from a PCP appointment for having a very high blood glucose level. The RNCM reviewed the hospital medical records in which the high level was attributed to sweet tea drinks the client had over the weekend. A later review of the medical records indicated that the client signed out of the hospital AMA (against medical advice). In the medical records the RNCM noted client's next scheduled appointment at HMC Adult Medicine and left a voice message for the client reminding him of it. She also requested the client call her back to follow-up on his recent hospitalization and the

progress on his self-care goals. The RNCM called the client a second time to follow-up. The client reported he was monitoring his blood glucose levels four times a day and gave her that day's levels.

### 2.4.3.5 Primary Care Diabetes Management.
The RNCM left two voice messages for the Chronic Care Manager at HMC requesting coordination of education and services for the client, as he recently had frequent ER visits and hospital admits for DKA.

The RNCM left the client a voice message requesting a call back to follow-up on his scheduled PCP appointment. On reviewing the medical records the client had cancelled the visit and rescheduled for a later date. The RNCM called the client's PCP and left a message stating she would like to follow-up with the PCP after the client's upcoming rescheduled appointment. The PCP responded favorably in an email.

The RNCM called the client to check in. He reported that he would be attending his rescheduled PCP appointment at HMC that evening and would call her the next day with an update. He also indicated he was continuing to monitor his blood glucose levels and gave her the levels for that day.

The PCP at Harborview Adult Medicine called the RNCM to update her about the client's appointment. She reported she increased his Metformin, referred him to diabetes education and a podiatrist, and encouraged him to keep a written log of his blood glucose levels. The RNCM also reviewed the medical records for the PCP visit. She called the client to follow-up on the appointment. He reported it went well, he had brought his Metro application which the provider signed, and he was now logging his blood glucose levels, as well as trying to exercise a little.

### 2.4.3.6 Stolen Glucometer.
The RNCM called the client to follow-up on his self care goals and he reported someone had stolen his glucometer several days ago so he hadn't been able to check his blood glucose. He reported taking his medications as prescribed. The RNCM advised the client to call the HMC Pharmacy to ask about getting

his glucometer replaced. The RNCM called the client's PCP at HMC to report the client's stolen glucometer. The PCP stated that the pharmacy would usually issue a second one in this case and stated the clinic would contact the client to arrange getting a new one. When the RNCM called the client later to follow-up on his self-care goals he reported that he had gone to the HMC Pharmacy and obtained a new glucometer. The client also reported his blood glucose levels for that day.

### 2.4.3.7 Podiatry.
The RNCM called the client to remind him that she would meet him at his podiatry appointment the following day.

The RNCM attended the client's podiatry appointment. The client was ten minutes late stating that his blood sugar was very high because he went out the night before.

### 2.4.3.8 Referrals.
The RNCM mailed the client a Senior Farmer's Market application.

### 2.4.3.9 ADS Resource Requests.
The RNCM sent an email to social services at ADS requesting medication management for the client.

The RNCM emailed the ADSCM asking her to follow-up with the client about housing applications, as he was not currently receiving a housing subsidy.

## 2.4.4  Client #4 (2/10/09 – 5/11/09)

### 2.4.4.1  Summary.
Client 4 had a complex constellation of medical and psychosocial issues, including chronic pain, domestic violence, housing problems, and prescription medication abuse. The client did not show up for her first two scheduled nursing assessments, attending the third. She then failed to attend an appointment with her mental health provider and the RNCM. The RNCM met the client at her home several times to facilitate podiatry care scheduling, and to help with housing by bringing a Section 8 Housing application for her landlord to sign. From mid February to mid May 2009 the client had two crises (medical and domestic violence) for which the RNCM fielded many frantic calls from her. In addition, she overdosed on her prescription medications resulting in a hospitalization in the ICU. Ultimately it was discovered that the client was committing Medicaid fraud and was terminated from RTC.

### 2.4.4.2 Enrollment.
Client 3 (650) was enrolled by I&A on their second attempted contact by phone. She is seen at the Seahurst Clinic and is frequently in bed due to pain. She is a client at DESC (Downtown Emergency Service Center) Mental Health and is called by her psychiatrist twice weekly.

The RNCM called the client and scheduled the Nurse Assessment. The RNCM missed the scheduled Nurse Assessment and rescheduled with the client. The client forgot about the rescheduled assessment and missed it so it was rescheduled again. When she arrived at the second rescheduled assessment, there was a note on the client's door canceling the appointment. The RNCM again rescheduled the appointment and it was successfully completed. The patient reported being very depressed and cried throughout the assessment. The client's partner was present for the assessment as well. After the assessment the RNCM sent the client a letter with various resources including information about pooled trusts. The client called the RNCM upset that the letter had referenced her need for a pooled trust. She calmed down when the RNCM explained it.

### 2.4.4.3 Mental Health and Chemical Dependency.

The RNCM called the client's case manager at DESC Mental Health and scheduled an appointment for the client which the RNCM planned to attend. The RNCM called the client and informed her of the date and time of the appointment to which client agreed.

The RNCM went to the appointment at DESC Mental Health, but the client did not show up. The RNCM and client's case manager briefly spoke about the client, agreeing that her greatest need was housing. The RNCM agreed to give the client a Section 8 housing form for her landlord to sign. They rescheduled the appointment for a later date at the client's home. The RNCM called the client and informed her of the date and time of the rescheduled appointment. They all successfully met on this date and time at client's home.

### 2.4.4.4 Overdose Hospitalization.

The client's partner called the RNCM reporting that she was in the Highline Medical Center ICU reportedly due to an accidental medication overdose. The RNCM called Highline who reported that the client was on a ventilator but in stable condition.

The RNCM called the client's sister and discussed concern about the client's safety regarding drug use when she receives settlement checks, and her partner's involvement in her prescription medication administration and drug use.

The RNCM staffed the client with her supervisor regarding the potential lethality of her drug use. The supervisor advised that as long as the client was mentally competent, there was nothing the RNCM could do to intervene.

### 2.4.4.5 Podiatry.

The RNCM called the client to follow-up on her orthotic appointment which the client reports she missed, but rescheduled for the next day.

The RNCM visited the client at her home. While there she helped her call the orthotic company to make an appointment to get her new shoes, as they had been ready for some time. The client and RNCM looked at client's feet together and the client agreed to make a podiatry appointment.

### 2.4.4.6 Acute Minor Medical Issue.

The client and the RNCM exchanged multiple phone messages regarding a genital blister about which the client was worried. The client reported keeping it clean, soaking it and applying antibiotic ointment, but wanted the RNCM to come to her home and help her.

### 2.4.4.7 Domestic Violence and Child Abuse.

The client left the RNCM a message at dawn, very upset, stating that she threw her partner out of the apartment. She stated he was trying to poison her, brought drugs to the home and encouraged her to use them, and stole her money. She stated that he had obtained a restraining order on her. The client called a second time, "hysterical", explaining she was served with restraining order papers for her partner's child. She stated that the behavior cited on the order happened a year ago and that she was worried it would go on her record. The

client later left a voice message ranting about her partner drinking in her apartment parking lot with his child in the back seat. The client left two additional voicemails expressing her distress about the restraining order, requesting the RNCM accompany her to court, and stating she was upset enough she thought she might need to go to inpatient treatment.

The RNCM called the client's case manager at DESC Mental Health to inform her of the current situation and find out when the client's next appointment with her is.

The client left a voice message for the RNCM requesting a call back to discuss her current situation with her partner. The RNCM called back and left the client a message explaining that she should be calling her DESC Mental Health case manager for this type of support.

*2.4.4.8 Termination Due to Medicaid Fraud.* The RNCM called the client to report that she was being terminated from the RTC program for fraud committed by receiving money through Medicaid to which she was not entitled. The client stated she had been receiving money and given most of it away. She also admitted acquiescing to her partner to purchase drugs with the money.

After receiving her official termination letter she left two messages for the RNCM inquiring about her Medicaid being rescinded and stating she was going to hire a lawyer.

## 2.5 Summary of Impressions
- Codes derived from open-ended comments made by the RNCMs are a potentially useful resource when considering ways to revise the discrete fields in the KCCP contact data base.
- The RN care managers routinely address and navigate complex constellations of varied medical, mental health, and psychosocial issues as well as organizations and systems with RTC clients.
- The micro steps involved in interacting and collaborating with clients' organizations and systems are extremely complex and time consuming, possibly demanding the majority of the RNCM's time.
- Only some of these issues demand the core competencies of an RN. A division of labor with social workers and other staff could free RN time to engage in more focused evidence-based interventions for chronic medical problems.
- Clients seem to cluster in certain profiles. For example, some clients have simultaneously active medical, mental health and social issues and possess poor self-management capabilities and skills, while others have only one active issue and have more functional self-management skills. Such differential client profiles may have implications for the efficacy of the intervention, as well as cost savings.

# 3. Summary, Conclusions, and Recommendations

## 3.1 Summary/Impressions of Qualitative Analyses
Codes derived from open-ended comments made by the RNCMs are a potentially useful resource when considering ways to revise the discrete fields in the KCCP contact data base.

- The RN care managers routinely address and navigate complex constellations of varied medical, mental health, and psychosocial issues as well as organizations and systems with RTC clients.
- The micro steps involved in interacting and collaborating with clients' organizations and systems are extremely complex and time consuming, possibly demanding the majority of the RNCM's time.
- Only some of these issues require the core competencies of an RN. A division of labor with social workers and other staff could free RN time to engage in more focused evidence-based interventions for chronic medical problems.
- Clients seem to cluster in certain profiles. For example, some clients have simultaneously active medical, mental health and social issues and possess poor self-management capabilities and skills, while others have only one active issue and have more functional self-management skills. Such differential client profiles may have implications for the efficacy of the intervention, as well as cost savings.

## 3.2 Conclusions and Recommendations
### 3.3.1 Recommendation for more efficient use of RN time
Scheduling and other activities that consume a large amount of RNCM time do not always require the core competencies of an RN. A division of labor with social workers and other staff could free RN time to engage in more focused evidence-based interventions for chronic medical problems.

### 3.3.2 Recommendations for revision of the KCCP data base
An observation from the CHAMMP evaluation team (and confirmed by KCCP directors) is that some of the current discrete fields in the data base are not as intuitive or clinically meaningful as they could be. As these are the primary notes for nurse and social work contacts with clients, we believe the codes and general entry should be optimized to be as user-friendly as possible.

- The categories of contacts that emerged from qualitative analyses of the open-ended comments have the potential to inform a revision of the KCCP contact data base. Because these codes were derived from open-ended comments made by the RNCMs, we believe they have high face validity and, as such, are likely to be viewed as intuitive and clinically meaningful by RTC intervention staff.

- For example, using codes derived in the category, 'Mode of Contact' (e.g, in person, phone, e-mail, fax, letter) could serve as a framework for the development of new discrete fields with some clarification from intervention staff. The categories, 'Intervention' (status, with client, for client) and "Qualifiers' (ineligibility/termination,

missed appointment, interventions client, collateral) could also be used as a start to clarifying more specific categories.

- Incorporating a broader array of discrete categories in place of some of the extensive open-ended comments could result in greater efficiencies for the RNCMs. Such a revision could also improve reliability and provide expanded ability to quantify contacts when content analysis cannot be carried out..

### 3.3.3 Recommendations for future research and examination

- Given our observation that clients appear to cluster in certain profiles (e.g., some with simultaneously active medical, mental health, and social issues while others have only one active issue and have more functional self-management skills), we recommend future evaluation efforts include systematic study of such client profiles in relation to outcomes.

- Although the analyses summarized in this report represent a good start on understanding the intervention being provided in the RTC project, they are limited by the information that has (and has not) been entered into the data base. For this reason, we recommend expanded inquiry in the future to supplement and enrich the available information in the KCCP data base. Results of further inquiry could serve as an important resource to more fully document project progress and, if conducted on a regular basis, to identify changes in the way the intervention is being provided.

- Although beyond the scope of the work carried out here, it will be important to define the structure of the intervention to assure uniformity across clinicians and linkage to an outcome monitoring system to facilitate client progress such as done in collaborative care models[3].

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[3] Gilbody, S., Bower, P., Fletcher, J., Richards, D., Sutton, A. J. (2006). Collaborative care for depression. A cumulative meta-analysis and review of longer-term outcomes. *Archives of Internal Medicine, 166*, 2314-2321. Katon, W., & Unutzer, J. (2006). Collaborative care models for depression. Time to move from evidence to practice. *Archives of Internal Medicine, 166*, 2304-2305.

## Appendix A

This Appendix contains a set of codes that were derived from the content analysis of the open-ended comments in the KCCP data base. We used Atlas.ti, qualitative data analysis software, to code the RTC contact log, ultimately constructing an account of the process of the RTC Project. To create the codes, one member of the research team read the full text of the contact log several times. Through an iterative process of assigning codes by reading the full text of the contact log multiple times, and reporting codes to and receiving feedback from the three other research team members once a week over the period of approximately a month, four major code categories, multiple code subcategories, and numerous codes were constructed.

The four major code categories are Staff (staff member), Mode of Contact (e.g. phone), Intervention (type of intervention), and Qualifiers (additional qualifying information). Staff is divided in to two categories: Role, and Staff (by name). Mode of Contact contains: In Person (e.g. meetings), Phone, Email, Fax, Letter, Other, and Recruiting (all contacts related solely to recruiting). Intervention is divided in to: Client Status (e.g. Assigned), Interventions with the Client, and Interventions for the Client (on behalf of the client). Qualifiers include reasons for ineligibility and missed appointments, further specificity of interventions, client qualifiers, collateral contact qualifiers, medical qualifiers, psychosocial qualifiers, and organizations and programs with which clients are involved.

| Staff | Mode of Contact | Intervention | Qualifiers |
|---|---|---|---|
| **ROLE**<br><br>ADSCM<br><br>RNCM<br><br>Other<br><br>I&A<br><br>**STAFF**<br><br>Flor Alarcon Medrano<br><br>Tia Hallberg<br><br>Susan Carstens<br><br>Jeanette Choate | **IN PERSON**<br><br>**Attend Client Appointment**<br><br>Attend client medical appointment<br><br>Attend client medical appointment, unsuccessful<br><br>Attend client mental health appointment<br><br>Attend client mental health appointment, unsuccessful<br><br>**Nurse Assessment**<br><br>RNCM Assessment<br><br>Completed RNCM Assessment<br><br>RNCM Assessment, Unsuccessful<br><br>**Home Visit**<br><br>Home Visit<br><br>Home visit, unsuccessful<br><br>**Meeting with Client**<br><br>Meeting with client<br><br>Meeting with client, unsuccessful<br><br>**Meeting with Collateral Contact**<br><br>Meeting with collateral contact, medical<br><br>Meeting with collateral contact, social services<br><br>Meeting with collateral contact, mental health<br><br>**PHONE**<br><br>**Call to Client**<br><br>Call to client<br><br>Call to client, wrong/disconnected number<br><br>Call to client, left message with person<br><br>Call to client, left voice message<br><br>Call to client, couldn't leave message | **STATUS**<br><br>I&A close<br><br>RDA<br><br>Enrolled<br><br>Assigned<br><br>Reassigned<br><br>Termination<br><br>**INTERVENTIONS WITH CLIENT**<br><br>Education/referrals<br><br>Follow-up<br><br>Request/concerns from client<br><br>Scheduling<br><br>Scheduled appointment<br><br>Rescheduled appointment<br><br>Inform/remind re: appointment<br><br>**INTERVENTIONS FOR CLIENT**<br><br>Care coordination<br><br>Client staffing<br><br>Facilitate services<br><br>*Scheduling<br><br>*Scheduled appointment<br><br>*in "Interventions with Client" as well | **INELIGIBILITY/TERMINATION**<br><br>Client ineligible<br><br>Client ineligible due to funding<br><br>Client ineligible due to long term care residence<br><br>Client not responding<br><br>Deceased<br><br>Unable to participate due to mental illness<br><br>Mental incompetence<br><br>**MISSED APPOINTMENT**<br><br>Client not feeling well<br><br>Declines RNCM's presence at appointment<br><br>Incorrect contact information<br><br>Incorrect information about appointment time/place<br><br>Interpreter no show<br><br>Participant/s no show<br><br>RNCM can't attend appointment<br><br>Missed appointment due to overlap<br><br>RNCM missed appointment<br><br>RNCM cancels appointment<br><br>RNCM cancels appointment due to illness<br><br>**INTERVENTIONS**<br><br>goals<br><br>medical self-care<br><br>medical supplies/equipment<br><br>medication management<br><br>incapacity determination<br><br>**CLIENT**<br><br>client behavior<br><br>intoxicated<br><br>client satisfaction<br><br>communication barrier |

## PHONE cont.

### Call from Client

Call from client

Call from client, left voice message

### Call to Collateral Contact

Call to collateral contact, caregiver

Call to collateral contact, caregiver, left message

Call to collateral contact, family/friend

Call to collateral contact, family/friend, left message

Call to collateral contact, medical

Call to collateral contact, medical, left message

Call to collateral contact, mental health

Call to collateral contact, mental health, left message

Call to collateral contact, social services

Call to collateral contact, social services, left message

Call to collateral contact, legal guardian

Call to project colleague

### Call from Collateral Contact

Call from collateral contact, caregiver, left message

Call from collateral contact, family/friend

Call from collateral contact, family/friend, left message

Call from collateral contact, social services, left message

Call from collateral contact, social services

Call from collateral contact, medical

Call from collateral contact, medical, left message

## EMAIL

### Email to Collateral Contact

Email to collateral contact, medical

## CLIENT cont.

client non-compliance

frequent healthcare visits

unhappy with medical care

AMA discharge

inpatient

inpatient psychiatric

---------------------------------------------

## COLLATERAL CONTACTS

interpreter

caregiver

payee

family/friends

legal guardian

pet

## EMAIL cont.

### Email to Collateral Contact cont.

**Email to project colleague**

**Email to collateral contact, social services**

### Email from Collateral Contact

**Email from collateral contact, medical**

**Email from collateral contact, social services**

## FAX

### Fax to Collateral Contact

**Fax to collateral contact, medical**

**Fax to collateral contact, mental health**

**Fax to collateral contact, social services**

### Fax from Collateral Contact

**Fax from collateral contact, medical**

## LETTER

### Letter to client

**Letter to client**

**Letter to client, unsuccessful**

### Letter to Collateral Contact

**Letter to collateral contact, caregiver**

**Letter to collateral contact, social services**

**Letter to collateral contact, legal guardian**

**Letter to collateral contact, medical**

**Letter to collateral contact, family/friend**

## OTHER

**Online searching**

**Paperwork**

**Prepare file for intial assessment**

**Review medical records**

**Translating**

**Interpreting**

## RECRUITING

### Call to Client

Recruiting call to client

Recruiting call to client, couldn't leave message

Recruiting call to client, left message with person

Recruiting call to client, wrong/disconnected number

Recruiting call to client, left voice message

### Call from Client

Recruiting call from client

Recruiting call from client, left message

### Call to Collateral Contact

Recruiting call to collateral contact, caregiver

Recruiting call to collateral contact, social services

Recruiting call to collateral contact, social services, left message

-------------------------------------------

### Call from Collateral Contact

Recruiting call from collateral contact, caregiver

Recruiting call from collateral contact, family/friend

Recruiting call from collateral contact, social services

### Letter to Client

Intro letter to client

Intro letter to client, unsuccessful

### Other

Demographic searching

|  | MEDICAL/BEHAVIORAL | SOCIAL | ORGANIZATIONS/ PROGRAMS |
|---|---|---|---|
| **Additional Qualifiers** | **Medical/Mental Health Problems** | **Languages** | **Mental Health/Chemical Dependency** |
|  | abdominal pain | Amharic | AA |
|  | ADLs | Cambodian | Asian Counseling and Referral |
|  | alcohol | Cantonese | CPC |
|  | ambulation | Vietnamese | Crisis Line |
|  | ankle | Ethiopian | DDD |
|  | anxiety | Oromo | DESC Mental Health |
|  | arthritis | Punjabi | Evergreen Treatment Services |
|  | asthma | Russian | Narcotics Anonymous |
|  | autism | Somali | Navos |
|  | back | Spanish | RCKC Detox |
|  | back pain | Urdu | Sound Mental Health |
|  | bone spur | Ukrainian | Therapeutic Health Services |
|  | brain tumor | Turkish | Thunderbird CD Treatment |
|  | bronchitis |  | Valley Cities Mental Health |
|  | bipolar disorder | **Client Social Needs/Issues** | WA DOH Quit Line |
|  | blind | appliances | **Healthcare** |
|  | blister | child abuse/neglect | Addus Healthcare |
|  | blood glucose | domestic violence | Auburn Community Health |
|  | cancer | employment | Carolyn Downs Clinic |
|  | cardiac | financial | Country Doctor |
|  | cardiac bypass | food/meals | Diabetes and Thyroid Southlake Clinic |
|  | cataracts | household supplies | Evergreen Hospice |
|  | chemical dependency | housekeeping | Georgetown Dental |
|  | CHF | housing | Harborview |
|  | chronic fatigue | illiteracy | HealthPoint |
|  | cognitive impairment | insurance | HealthPoint Auburn |
|  | COPD | legal | HealthPoint Bellevue |
|  | cough | restraining order | HealthPoint Eastside |
|  | eye | transportation | HealthPoint Federal Way |
|  | fall | transitional housing | HealthPoint Kent |
|  | feet |  |  |

| | MEDICAL/BEHAVIORAL cont. | | ORGANIZATIONS/ PROGRAMS cont. |
|---|---|---|---|
| | Medical/Mental Health Problems cont. | | Healthcare cont. |
| | fibromyalgia | | Washington Wound Clinic |
| | fracture | | Highline Medical Center |
| | GERD | | Highline Primary Care |
| | | | Kenmore/Bothell HealthPoint |
| | glaucoma | | Lake City Clinic |
| | gout | | Overlake Eye Care |
| | groin pain | | Pacific Medical Center |
| | grief/loss | | Pacific Medical Center Northgate |
| | headaches | | |
| | hearing impairment | | Pike Market Clinic |
| | heart attack | | Pioneer Square Clinic |
| | heart failure | | Rainier Beach Clinic |
| | hepatitis | | Rainier Clinic |
| | hernia | | Rainier Park Clinic |
| | HHNK | | Rainier Park Medical Clinic |
| | hip replacement | | Roxbury Clinic |
| | hoarding | | Seahurst Clinic |
| | hot flashes | | SeaMar |
| | hypertension | | Seattle Cancer Care Alliance |
| | impotence | | Seattle Hand Clinic |
| | kidneys | | Seattle Indian Health Board |
| | knee | | Snoqualmie Valley Hospital |
| | leg pain | | St Francis Hospital |
| | leukemia | | St Francis Medical Clinic |
| | liver | | St Francis Weight Loss Clinic |
| | lungs | | Swedish Cancer Institute |
| | lupus | | Swedish Family Medicine |
| | mental illness | | Swedish Medical Center |
| | mobility | | Symmetry Physical Therapy |
| | mood disorder | | UW Medical |
| | neck pain | | Valley Medical Center |
| | | | HealthPoint Renton |

| | MEDICAL/BEHAVIORAL cont. | | ORGANIZATIONS/ PROGRAMS cont. |
|---|---|---|---|
| | **Medical/Mental Health Problems** cont. | | **Medical Equipment** |
| | neuropathy | | Contemporary Medical Supply |
| | obesity | | Care Medical |
| | osteoporosis | | Bellevue Home Care |
| | overdose | | **Aging/Disability Residences** |
| | pain | | AFH |
| | pancreatitis | | assisted living |
| | panic disorder | | Cannon House |
| | Parkinson's | | Care and Share House |
| | personality disorder | | ElderHealth |
| | pneumonia | | ElderPlace |
| | psychosis | | Evans House |
| | PTSD | | Evergreen Homecare |
| | pulmonary embolism | | Evergreen Lodge |
| | rash | | Francis House |
| | respiratory | | Fritz Care Services |
| | respiratory failure | | Hallmark Manor |
| | scalp | | Leon Sullivan SNF |
| | schizoaffective disorder | | Life Care Center |
| | schizophrenia | | SeaMar Community Care Center |
| | seizure | | SNF |
| | shoulder | | Talbot Center SNF |
| | shoulder pain | | **Transportation** |
| | sleep | | ACCESS |
| | sleep apnea | | Hopelink |
| | spine | | Metro |
| | stomach pain | | **Housing** |
| | stroke | | boarding home |
| | suicidal | | Josephinum |
| | ulcer | | Morrison Hotel |
| | vision | | Plymouth Housing |
| | weight | | Section 8 |

## MEDICAL/BEHAVIORAL cont.
### Medical/Mental Health Problems cont.

withdrawal symptoms

#### Medical Interventions/Disciplines

acupuncture

amputation

bariatric surgery

behavioral health

chemical dependency treatment

colonoscopy

gastric surgery

gastroenterology

INR

IV fluids

liver transplant

MRI

neurology

neurosurgery

occupational therapy

oncology

opthamology

optometry

orthopedic

orthotics

pain management

pharmacy

PHQ9

physical therapy

podiatry

PPD

psychiatry

rehab

respite care

## ORGANIZATIONS/ PROGRAMS cont.
### Housing cont.

SHA

Simon Apartments

Wintonia Hotel

Union Gospel Mission

DESC

#### Programs/Resources

AACRES

ADSA

APS

Bandero Program

COPES

CORE

CPS

Department of Vocational Rehabilitation

DSHS

HUG

Long Term Care Services

MPCS

New Freedoms

PEARLS

Rainier CSO

SL Start

Amy Wong funds

Northwest Justice Project

People Helping People

Senior Farmer's Market

#### Public Assistance/Insurance

GAU

SSI/SSA

Medicaid

Medicare

## MEDICAL/BEHAVIORAL cont.
### Medical Interventions/Disciplines
cont.

rheumatology

ROI

ROM

sleep specialist

smoking cessation

surgery

tooth extraction

urology

wound care

xray

ICU

hospice

### Medications

antibiotics

antidepressant

benzodiazepines

Chantix

chemotherapy

Coumadin

Fentanyl

gabapentin

insulin

lithium

Metformin

methadone

Methotrexate

Metropolo

narcotics

Omeprazole

opiates

Percocet

## MEDICAL/BEHAVIORAL cont.
### Medications cont.

**Prozac**

**Ranitidine**

**Ritalin**

**Senemet**

**Tegretol**

**Warfarin**

**Zoloft**

**medications**

### Medical Equipment

**catheter**

**glucometer**

**inhaler**

**nebulizer**

**peak flow meter**

**spirometer**